STATE OF TENNESSEE

DEPARTMENT OF COMMERCE AND INSURANCE

TENNCARE DIVISION

and

THE OFFICE OF THE COMPTROLLER OF THE TREASURY

DIVISION OF STATE AUDIT

MARKET CONDUCT EXAMINATION

and

LIMITED SCOPE FINANCIAL AND COMPLIANCE EXAMINATION

OF

PREFERRED HEALTH PARTNERSHIP OF TENNESSE, INC.

KNOXVILLE, TENNESSEE

FOR THE PERIOD JANUARY 1, 2003
THROUGH DECEMBER 31, 2005

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DATE: December 28, 2006

The examination fieldwork for a Limited Scope Financial and Compliance Examination and Claims Processing Market Conduct Examination of Preferred Health Partnership of Tennessee, Inc., Knoxville, Tennessee, was completed July 26, 2006. The report of this examination is herein respectfully submitted.

I. FOREWORD

On December 17, 2003, the TennCare Division of the Tennessee Department of Commerce and Insurance (TDCI) notified Preferred Health Partnership of Tennessee, Inc., (PHPT) of its intention to perform a market conduct and limited scope financial statement examination. Fieldwork began on March 1, 2004, and ended on March 11, 2004. On May 1, 2004, PHPT's independent auditors, Pershing Yoakley & Associates, P.C., disclaimed an opinion on PHPT's 2003 audited financial statements. A disclaimer of opinion indicates the auditor does not express an opinion on the financial statements. TDCI was concerned about the disclaimed opinion and increased regulatory oversight of PHPT by extending the examination period. A disclaimer of opinion was also issued on the audited financial statements for calendar years 2004 and 2005. On May 17, 2006, TDCI notified PHPT of its intention to extend the 2003 examination to include fiscal years 2004 and 2005. TDCI completed fieldwork on July 26, 2006.

This report includes the results of a market conduct examination "by test" of the claims processing system of Preferred Health Partnership of Tennessee, Inc. Further, this report reflects the results of a limited scope examination of financial statement account balances as reported by PHPT. This report also reflects the results of a compliance examination of PHPT's policies and procedures regarding statutory and contractual requirements. A description of the specific tests applied is set forth in the body of this report and the results of those tests are included herein.

II. PURPOSE AND SCOPE

A. Authority

This examination of PHPT was conducted jointly by TDCI and the Office of the Comptroller of the Treasury, Division of State Audit (Comptroller) under the authority of Section 3-6. of the Contractor Risk Agreement (CRA) between the State of Tennessee and PHPT, Executive Order No. 1 dated January 26, 1995, and Tennessee Code Annotated (Tenn. Code Ann.) § 56-32-215 and § 56-32-232.

PHPT is licensed as a health maintenance organization (HMO) in the state and participates by contract with the state as a managed care organization (MCO) in the TennCare Program. The TennCare Program is administered by the TennCare Bureau within the Tennessee Department of Finance and Administration.

B. Areas Examined and Period Covered

The market conduct examination focused on the claims processing functions and performance of PHPT. The testing included an examination of internal controls surrounding claims adjudication, claims processing system data integrity, notification of claims disposition to providers and enrollees, and payments to providers.

The limited scope financial examination focused on selected balance sheet accounts and the TennCare income statement as reported by PHPT on its National

Association of Insurance Commissioners (NAIC) annual statements for the periods ended December 31, 2003 and 2005, and the Medical Services Monitoring Report filed by PHPT as of December 31, 2005.

The limited scope compliance examination focused on PHPT's provider appeals procedures, provider agreements and subcontracts, the demonstration of compliance with non-discrimination reporting requirements and the Insurance Holding Company Act.

Fieldwork was performed using records provided by PHPT before and during the onsite examination of records from March 1, 2004 through March 11, 2004, and July 10 through July 26, 2006.

C. Purpose and Objective

The purpose of the examination was to obtain reasonable assurance that PHPT's TennCare operations were administered in accordance with the CRA and state statutes and regulations concerning HMO operations, thus reasonably assuring that PHPT TennCare enrollees received uninterrupted delivery of health care services on an ongoing basis.

The objectives of the examination were to:

- Determine whether PHPT met certain contractual obligations under the CRA and whether PHPT was in compliance with the regulatory requirements for HMOs set forth in Tenn. Code Ann. § 56-32-201 *et seq.*;
- Determine whether PHPT had sufficient financial capital and surplus to ensure the uninterrupted delivery of health care services for its TennCare members on an ongoing basis;
- Determine whether PHPT properly adjudicated claims from service providers and made payments to providers in a timely manner;
- Determine whether PHPT had implemented an appeal system to reasonably resolve appeals from TennCare providers in a timely manner; and
- Determine whether PHPT had corrected deficiencies outlined in prior examinations of PHPT conducted by TDCI.

III. PROFILE

A. Administrative Organization

Preferred Health Partnership of Tennessee, Inc., was chartered in the state of Tennessee on September 3, 1993, for the purpose of providing managed health care services to individuals participating in the state's TennCare Program. PHPT is a wholly-owned subsidiary of PHP Companies, Inc. (PHP), which also owns other

health insurance and insurance-related subsidiaries and is itself a majority-owned subsidiary of Covenant Health.

On January 1, 1994, PHPT contracted with the state as a preferred provider organization. On December 31, 1996, TDCI granted PHPT a certificate of authority to operate as an HMO.

The officers and board of directors for PHPT at December 31, 2005, were as follows:

Officers for PHPT

Lance K. Hunsinger, President
Jeffrey S. Collake, Chief Financial Officer
Jeffrey S. Collake, Secretary

Board of Directors for PHPT

Kenneth T. Creed	Thomas R. Bell
Michael M. Dudley	Daniel J. David, MD
Randolph M. Lowry, MD	Marvin H. Eichorn
Cletus J. McMahon Jr., MD	Kenneth F. Luckman, MD
David A. Nowiski	Michael E. Mitchel, MD
Anthony L. Spezia	Francis H. Olmstead Jr.
Sandra L. Mathy	Dean M. Turner, MD

B. Brief Overview

Effective July 1, 2002, the CRA with PHPT was amended for PHPT to temporarily operate under a non-risk agreement. This period, otherwise known as the "stabilization period," was established to allow all MCOs a satisfactory period of time to establish financial stability, maintain continuity of a managed care environment for enrollees and assist the TennCare Bureau in restructuring the program design to better serve Tennesseans adequately and responsibly. PHPT agreed to reimburse providers for the provision of covered services in accordance with reimbursement rates, reimbursement policies and procedures, and medical management policies and procedures as they existed April 16, 2002, unless such a change received approval in advance by the TennCare Bureau.

During stabilization, PHPT receives from the TennCare Bureau a monthly fixed administrative payment based upon the number of TennCare enrollees assigned to PHPT. The TennCare Bureau reimburses PHPT for the cost of providing covered services to TennCare enrollees.

PHPT is currently authorized by TDCI and the TennCare Bureau to operate in the community service areas of First Tennessee, East Tennessee, Knox County, Southeast Tennessee, and Hamilton County which comprise the East Tennessee Grand Region. All premium revenue earned by PHPT is from payments received for enrollees assigned by the TennCare Bureau. PHPT reported enrollment of

approximately 131,000 as of December 31, 2003, 131,600 as of December 31, 2004, and 117,700 as of December 31, 2005.

C. Claims Processing Not Performed by PHPT

TennCare has contracted with other organizations for the administration and claims processing of these types of services:

- Dental
- Pharmacy
- Behavioral Health

During the period under examination, PHPT did not subcontract with vendors for the provision of specific TennCare benefits and the processing and payment of related claims submitted by providers.

IV. PREVIOUS EXAMINATION FINDINGS

The previous examination findings are provided for informational purposes. The following were financial, claims processing and compliance deficiencies cited in the examination by the TDCI for the period January 1, 2000, through December 31, 2000:

A. Financial Deficiencies

1. PHPT did not obtain an actuarial certification of three liabilities (Reserve for Transplants, Accrued Run Out Cost, and Grier Decree Reserve) and one loss contingency (Reserve for Contingent Operating Losses) reported on its NAIC 2000 Annual Financial Statement.
2. PHPT incorrectly reported rebates from its pharmacy provider as miscellaneous income.
3. PHPT incorrectly reported IBNR medical expense as a single line item in the NAIC statement.
4. The “Accounts Receivable – UPA” account was overstated by $7,721.

These deficiencies were not repeated in this report.

B. Claims Processing Deficiencies

1. PHPT did not process claims in accordance with the TennCare Contract. Only 95% of all claims in the sample were processed within 60 days. The TennCare contract requires an MCO to process 100% of all claims within 60 days.
2. Three claims were not paid in accordance with the appropriate fee schedule.
3. One denied claim did not list all of the appropriate denial codes.

4. Keying errors for two provider claims incorrectly created deductibles. One claim showed a deductible of $0.08 and one claim showed $1500. Furthermore, PHPT did not pay the provider for a claim. The allowed amount and the deductible were equal.
5. The claims processing system did not correctly calculate a copay for one enrollee.
6. PHPT did not provide EOBs for 8 claims.
7. PHPT did not provide the remittance advice (explanation of plan) for 1 claim.
8. Seven claims did not have all the diagnosis codes from the claim entered in the claims processing system.
9. The pend report reviewed indicated 64 claims in a suspended status for more than 60 days. The TennCare contract requires that 100% of all claims be processed within 60 days.

These deficiencies were not repeated in this report.

C. Compliance Deficiencies

1. PHPT did not respond timely to appeals received from providers. PHPT took longer than 60 days to resolve 55 of 82 provider appeals reviewed.
2. PHPT did not submit its administrative services contract to the TennCare Bureau for approval.
3. PHPT did not pay all subcontractors timely in accordance with the terms of the subcontract.
4. PHPT did not submit the required statutory filing relative to the HMO holding company system by the due date.

Deficiencies number 1 and 2 are repeated as part of this report.

V. SUMMARY OF CURRENT FINDINGS

The summary of current factual findings is set forth below. The detail of testing as well as management comments to each finding can be found in Sections VI, VII, and VIII of this examination report.

A. Financial Deficiencies

1. PHPT did not properly report as cash certain cash balances as required by Statement of Statutory Accounting Principle (SSAP) No. 2. (See Section VI.A.4.)
2. PHPT's quarterly statement for the third quarter of 2003 reflected an extraordinary distribution of $9,133,336. This extraordinary distribution was not approved by the Commissioner as required by Tenn. Code Ann. §56-11-206(b)(1). A Cease and Desist Order was issued by the Commissioner on March 29, 2004. (See Section VI.A.5.)

3. PHPT uses the straight-line method to amortize bond premium and discount. SSAP No. 26 requires the use of the scientific method. (See Section VI.A.6.)
4. PHPT improperly classified $5,009,143 due to the TennCare Bureau for Risk Share Audit Reserve, Penalty Reserve State Risk, and Reserve for at Risk Revenues as General Expenses Due or Accrued on the NAIC financial statements. (See Section VI.A.7.)
5. PHPT failed to obtain prior approval from TDCI and the TennCare Bureau before executing a subcontract for management services in violation of Sections 2-9.c and 2-17 of the CRA and Tenn. Code Ann. § 56-32-203(c)(1). (See Section VI.A.8.)
6. A two to one allocation of indirect costs to charge management fees to PHPT through an unapproved management agreement is not a proper method to allocate shared expenses. This method does not yield the most accurate results. (See Section VI.A.8).

B. Claims Processing Deficiencies

1. PHPT was not in compliance with the prompt pay requirements of Tenn. Code Ann. §56-32-226(b) for claims processed during July 2003, March 2006, and April 2006. (See Section VII.A.)
2. PHPT did not pay claims accurately for the second quarter of 2006 in accordance with Section 2-9 of the CRA, which requires that 97% of claims be paid accurately upon initial submission. (See Section VII.C.)
3. Five of ten claims judgmentally selected from incoming mail were not posted to the claims processing system due to a systems control failure. (See Section VII.G.)

C. Compliance Deficiencies

1. PHPT failed to respond to all provider complaints in accordance with Tenn. Code Ann. § 56-32-226. (See Section VIII.A.)
2. The provider manual currently in use by PHPT was not prior approved by TDCI as required by Tenn. Code Ann. § 56-32-203(c)(1). (See Section VIII.B.)
3. PHPT failed to provide evidence that providers received amendments to their provider agreements as required by Section 2-18.cc of the CRA. (See Section VIII.C.)
4. PHPT executed a transportation subcontract without prior approval as required by Section 2-9.f. and 2-17 or the CRA. (See Section VIII.E.)
5. PHPT violated Holding Company requirements of Tenn. Code Ann. § 56-11-206(a)(2)(D), prior approval of management agreements, and Tenn. Code Ann. § 56-11-206(b)(1) prior approval of extraordinary distributions. (See Section VIII.I)
6. Interest earned for September 2005, October 2005 and November 2005 was not returned to the State in a timely manner per Section 3-10.h.2.(d) of the CRA. (See Section VIII.K.4.)

7. Subrogation amounts collected for October through November 2005 were not returned to the State in a timely manner per Section 3-10.h.2.(f) and (g) of the CRA. (See Section VIII.K.5.)

VI. DETAIL OF TESTS CONDUCTED – FINANCIAL ANALYSIS

A. Financial Analysis

As an HMO licensed in the State of Tennessee, PHPT is required to file annual and quarterly NAIC financial statements with the Tennessee Department of Commerce and Insurance in accordance with NAIC and statutory guidelines. The department uses the information filed on these reports to determine if PHPT meets the minimum requirement for statutory reserves. The statements are filed on a statutory basis of accounting. Statutory accounting differs from generally accepted accounting principles because "admitted" assets must be easily convertible to cash, if necessary, to pay outstanding claims. "Non-admitted" assets such as furniture, equipment, and prepaid expenses are not included in the determination of plan assets and should not be considered when calculating capital and surplus.

At December 31, 2003, PHPT reported $59,027,669 in admitted assets, $37,841,106 in liabilities and $21,186,563 in capital and surplus on its NAIC annual statement. PHPT reported net income of $3,214,571 on its statement of revenue and expenses.

At December 31, 2004, PHPT reported $62,005,506 in admitted assets, $35,744,876 in liabilities and $26,260,630 in capital and surplus on its NAIC annual statement. PHPT reported net income of $5,074,067 on its statement of revenue and expenses.

At December 31, 2005, PHPT reported $59,028,032 in admitted assets, $23,683,129 in liabilities and $35,344,903 in capital and surplus on its NAIC annual statement. PHPT reported net income of $9,122,977 on its statement of revenue and expenses.

1. Capital and Surplus

Tenn. Code Ann. § 56-32-212(a)(2) requires PHPT to establish and maintain a minimum net worth equal to the greater of (1) $1,500,000 or (2) an amount totaling 4% of the first $150 million of annual premium revenue earned for the prior calendar year, plus 1.5% of the amount earned in excess of $150 million for the prior calendar year.

Tenn. Code Ann. § 56-32-212(a)(2) includes in the definition of premium revenue "any and all payments made by the state to any entity providing health care services pursuant to any federal waiver received by the state that waives any or all of the provisions of the federal Social Security Act (title XIX), and regulations promulgated pursuant thereto, or pursuant to any other federal law as adopted by amendment to the required title XIX state plan..." Based on this definition, all TennCare payments made to an HMO licensed in Tennessee are to be included in the calculation of net worth and deposit requirements, regardless of the reporting requirements for the NAIC statements.

2005 Statutory Net Worth Calculation

PHPT's premium revenue per documentation obtained from the TennCare Bureau totaled $233,141,443 for the calendar year 2005; therefore, based upon Tenn. Code Ann. § 56-32-212(a)(2), PHPT's statutory net worth requirement for the calendar year 2005 is $7,247,122. PHPT reported total capital and surplus of $35,344,903 as of December 31, 2005, which is $28,097,781 in excess of the minimum statutory net worth requirement.

Premium Revenue for the Examination Periods

The following is a summary of PHPT's premium revenue as defined by Tenn. Code Ann. § 56-32-212(a)(2) by fiscal year:

Calendar Year 2003

Administrative fee payments from TennCare for the period January 1 through December 31, 2003	$18,107,482
Reimbursement for medical payments from TennCare for the period January 1 through December 31, 2003	240,862,981
Reimbursement for premium tax payments from TennCare for the period January 1 through December 31, 2003	4,018,014
Total premium revenue for 2003	$262,988,477

Calendar Year 2004

Administrative fee payments from TennCare for the period January 1 through December 31, 2004	$20,692,704
Reimbursement for medical payments from TennCare for the period January 1 through December 31, 2004	214,098,616
Reimbursement for premium tax payments from TennCare for the period January 1 through December 31, 2004	4,446,428
Total premium revenue for 2004	$239,237,748

Calendar Year 2005

Administrative fee payments from TennCare for the period January 1 through December 31, 2005	$18,459,836
Reimbursement for medical payments from TennCare for the period January 1 through	

December 31, 2005	210,186,113
Reimbursement for premium tax payments from TennCare for the period January 1 through December 31, 2005	4,495,494
Total premium revenue for 2005	$233,141,443

2. Restricted Deposit

Beginning July 1, 2005, an amendment to the CRA required MCOs to have on restricted deposit an amount equal to the calculated statutory net worth. Based upon premium revenues for calendar year 2005 totaling $233,141,443, PHPT's statutory deposit requirement at December 31, 2005, is $7,247,122. PHPT had on file with TDCI the necessary safekeeping receipts documenting that deposits totaling $7,550,000 had been pledged for the protection of the enrollees in the State of Tennessee.

3. Claims Payable

As of December 31, 2005, PHPT reported no claims unpaid on the NAIC annual statement. Claims unpaid represents an estimate of unpaid claims or incurred but not reported (IBNR) for only the "at risk" period ending June 30, 2002. Review of the triangle lag payment report after December 31, 2005, through June 30, 2006, for dates of services before July 1, 2002, determined that the reported claims payable appears reasonable.

4. Cash and Cash Equivalents

PHPT reported cash of $242,314 on its 2005 annual statement. The reported cash balance did not include institutional cash of $196,936 as required by Statutory Accounting Principle No. 2. This amount was reported incorrectly in admitted bonds. The reclassification of these cash items will not affect net income or net worth.

Management's Comments

Management concurs with the reclassification of the institutional cash.

5. Extraordinary Distribution

PHPT's September 2003 Quarterly Statement included a distribution to PHPT's parent company PHPC of $9,133,336. This distribution was deemed an extraordinary distribution as defined in Tenn. Code. Ann. § 56-11-206(b)(2). The distribution of $9,133,336 exceeded ten percent (10%) of the reported total capital and surplus of $17,929,640 as reported on PHP's 2002 NAIC Annual

Statement and the distribution was greater than net income for the preceding twelve months.

This extraordinary distribution was not prior approved by the Commissioner of Commerce and Insurance as required by Tenn. Code. Ann. § 56-11-206(b)(1). This statute states, in pertinent part:

> "no domestic insurer and no health maintenance organization shall pay an extraordinary dividend or make any other extraordinary distribution to its shareholders until thirty (30) days after the Commissioner has received notice of the declaration thereof and has not within such period disapproved such payment or….approved such payment within such thirty-day period."

On March 29, 2004, the Commissioner of Commerce and Insurance issued a Cease and Desist Order because of the violations of Tenn. Code. Ann. § 56-11-206(b)(1). On April 16, 2004, PHPT agreed to comply with the order. Additionally, cash and receivables of the parent company were utilized to return the extraordinary distribution to PHPT.

Management's Comments

Management concurs.

6. Amortization of Bond Premium and Discount

PHPT amortizes bond premium and discount using the straight-line method. SSAP No. 26 requires reporting entities to use the scientific method. Even though the difference between the straight-line method and the scientific method is not material, PHPT should follow the guidance offered in SSAP No. 26.

Management's Comments

Management concurs.

7. General Expenses Due or Accrued

PHPT included the following amounts in General Expenses Due or Accrued as of December 31, 2005:

Accounts Payable	$22,286
Risk Share Audit Reserve	2,040,320

Penalty Reserve State Risk	2,568,750
Reserve for at Risk Revenue	400,073
Unclaimed Property	135,652
Premium Tax Accrual	79,458
Total	$5,246,539

During the examination, PHPT provided the following explanation for these accounts:

- **Risk Share Audit Reserve –** This accrual includes PHPT's calculation of possible violations and errors by PHPT related to the CRA for the period July 2000 through June 2002.

- **Penalty Reserve State Risk –** This liability is an accrual for potential performance penalties addressed in the administrative contract with the state.

- **Reserve for at Risk Revenue –** In July 2005, PHPT began accruing 5% of at-risk revenue for administrative premiums only under the new TennCare CRA.

- **Unclaimed Property** – The balance in this account represents outstanding claims payments that have not cleared.

- **Premium Tax** – This account represents PHPT's liability for premium tax to the state.

In accordance with NAIC Annual Statement Instructions, only Accounts Payable of $22,286 should be recorded as General Expenses Due and Accrued. The NAIC Annual Statement Instructions defines General Expenses Due and Accrued as "amounts due to creditors (trade vendors rather than health care providers) for the acquisition of goods and services on a credit basis." The Risk Share Audit Reserve, Penalty Risk Reserve, Reserve for at Risk Revenue and Unclaimed Property should be reported as write-ins on the Statement of Liabilities, Capital and Surplus, line 21. Premium tax accrual should be reported on Line 20, Liability for amounts held under uninsured accident and health plans on the Statement of Liabilities, Capital and Surplus. The reclassification of these liabilities will not affect net worth or capital and surplus.

Additionally, SSAP No. 5 indicates loss contingencies should be recorded by a charge to operations if a liability has been incurred at the date of the statutory financial statement and the loss can be reasonably estimated. PHPT has not provided examples where PHPT has violated the CRA or failed to meet specific performance requirements which when calculated would result in $5,009,143 due to the TennCare Bureau for Risk Share Audit Reserve, Penalty Reserve State Risk, and Reserve for at Risk Revenue. All three liabilities were based upon estimates determined by the management of PHPT. The management of PHPT

should seek to resolve these material liabilities with the TennCare Bureau or increase internal controls to provide assurances that the CRA has not been violated and thus precluding the necessity of recording such liabilities.

Management's Comments

Management has attempted to resolve these liabilities through dialog with the TennCare Bureau and TDCI. At this point in time, no definitive answer has been received from the Bureau on the status of these particular reserves.

8. Management Agreement

PHPT contracts with the parent, PHPC, for administrative services through a service agreement. PHPC provides PHPT employee services, office space, equipment and supplies. The services agreement was not submitted to the TennCare Division of the Department of Commerce and Insurance before execution on January 1, 2000. PHPT did not file notice and obtain the commissioner's prior approval before making material modifications to the operational documents of the HMO in accordance with Tenn. Code Ann. § 56-32-203(c)(1). Additionally, PHPT did not submit this subcontract for prior approval by the TennCare Bureau per Sections 2-9.f. and 2-17 of the CRA.

PHPT's continued use of unapproved operational documents is a violation of PHPT's Certificate of Authority and the CRA. TDCI reserves the right to pursue penalties as described in Tenn. Code Ann. § 56-32-220 and Tenn. Code Ann. § 56-32-216.

Management's Comments

Management does not concur. A material modification was filed with Commerce and Insurance. The agreement was not approved based on the following language notation.

On June 25, 2004, PHPT filed the management agreement for approval as a material modification with the TennCare Division of the Department of Commerce and Insurance. The management agreement defines the amount the parent, PHPC, charges the TennCare HMO and other subsidiaries for administrative services that PHPC performs. The management agreement allows PHPC to allocate and charge management expenses not directly attributable to a specific subsidiary on a 1:1 basis for commercial lines and a 2:1 basis for its government programs. The allocation methodology used is based on the budgeted enrollment of each subsidiary.

To illustrate the allocation basis described in the management agreement, the 2005 allocation percentage was determined by PHPT as follows:

Program Type	Budgeted Enrollment	Adjustment for 2:1 Allocation	Percentage
	90,600	90,600	22.62%

Commercial			
Medicare	24,929	49,858	12.45%
TennCare	130,000	260,000	64.93%
Total	245,529	400,458	100%

Below is a comparison of the indirect administrative expense allocated to PHPT using the 2:1 allocation method and the administration expenses directly incurred by PHPT to the administrative revenue paid by TennCare to PHPT for calendar year 2005.

Allocation of Administrative Expense Charged by the Parent to PHPT for 2005	$17,726,084
Administrative Expense Incurred Directly by PHPT for 2005	3,285,764
Total Administrative Expenses for 2005	$21,011,848
Administrative Revenue from the TennCare Bureau for 2005	$18,459,836
Excess Administrative Expenses over Administrative Revenue	$2,552,012

A Notice of Filing Deficiency was sent on August 20, 2004, in response to PHPT's request for approval of the management agreement on June 25, 2004. In this letter, TDCI requested PHPT to provide (1) evidence of TennCare Bureau approval and (2) all support for the 2:1 allocation of expense to government programs. PHPT did not provide evidence of TennCare Bureau approval. From the support later provided by PHPT, TDCI could not find sufficient evidence to indicate costs incurred by PHPC for a TennCare enrollee should be charged at twice the rate for an enrollee in a commercial line of business. A significant portion of the expenses by PHPC on the behalf of PHPT was salary and wage related expenses. PHPT did not provide time studies of employee activities to support the premise that serving TennCare enrollees requires exactly twice the amount of staff time to perform duties related to commercial enrollees. Additionally, as plan requirements and experience with operations change from year to year, a 2:1 allocation for one year may not always be true in subsequent years.

For 2005, total administrative expenses of $35,155,078 were allocated to PHPC's subsidiaries. Of this amount, PHPT received $17,726,084 or 50.42% in allocated management expenses.

SSAP No. 70 establishes statutory accounting principles for presentation and allocation of certain expenses of reporting entities into general categories and the

apportionment of shared expenses between members of a group of entities.

SSAP No. 70 offers the following guidance for allocating management expenses:

> Shared expenses, including expenses under the terms of a management contract, shall be apportioned to the entities incurring the expense as if the expense had been paid solely by the incurring entity. The apportionment shall be completed based upon specific identification to the entity incurring the expense. Where specific identification is not feasible apportionment shall be based upon pertinent factors or ratios.

SSAP No. 70 also states that any basis adopted to apportion expenses should be the one which yields the most accurate results. The methodology should be based on special studies of employee activities, salary ratios, premium ratios or similar analyses. Expenses that relate solely to the operations of a reporting entity, such as personnel costs associated with the adjusting and paying of claims, must be borne solely by the reporting entity and are not to be apportioned to other entities within a group.

PHPT should amend the terms of the management agreement so that the allocation and charge of administrative expenses of the parent are based upon methods described in SSAP 70. Where expenses incurred by PHPC are not directly attributable to a specific subsidiary, an allocation method should be adopted that yields the most accurate results for the current period and future periods.

Management Comments

As stated in previous correspondence with Department of Commerce and Insurance, Management believes the allocation methodology prescribed in the management agreement more accurately depicts the expenses that would be incurred if the company was stand alone than any other methodologies. Management is aware of the language of both SSAP 70 and Issue Paper 94 and the current methodology complies with the intent and guidelines of both SSAP 70 and Issue Paper 94.

9. Liabilities and Reserve

PHPT reported actuarially certified liabilities in addition to unpaid claims as Aggregate Health Policy Reserves and Accrued Runout Costs. These reserve liabilities were established by recording the reserve liabilities as an expense in prior periods' Statement of Revenue and Expenses. The additional liabilities represent cost that PHPT expects that it will incur related to the TennCare contract where administrative costs exceed future administrative payments from the State. The following table provides year end balances and changes for the additional liabilities:

Account	Balance 12/31/2003	Change	Balance 12/31/2004	Change	Balance 12/31/2005
Aggregate Health Policy Reserves	10,826,641	0	10,826,641	(4,094,641)	6.732,000
Accrued Runout Costs	14,082,990	0	14,082,990	(2,594,385)	11,488,605
Total	$24,909,631	0	$24,909,631	$(6,689,026)	$18,220,605

The recognition of the additional liabilities along with other losses from operations in prior periods resulted in net deferred tax assets. The balances of the net deferred tax assets were $14,545,510 as of December 31, 2003, $12,701,214 as of December 31, 2004, and $7,852,188 as of December 31, 2005. The net deferred tax assets were non-admitted by PHPT for statutory accounting purposes. The notes to the audited financial statements for the year ended December 31, 2005 included the following explanation:

> The decrease of approximately $4,849,000 in the non-admitted deferred tax assets during 2005 is due primarily to the reduction of estimated aggregate policy reserves. There are no provisions for income taxes in 2005 due to utilization of net operating loss carryforwards and nonadmitted deferred tax assets. The current income tax benefit for 2005 is $249,424, which represents amounts owed from affiliates for use of the Company's current year taxable loss.

As previously noted, TDCI has not approved the management agreement which is the basis for excess administrative costs utilized in the calculation of the additional liabilities and the resulting net deferred asset. TDCI finds that the additional liabilities and net deferred tax asset are unsupported without an approved management agreement; however TDCI does not recommend an adjustment to the reported reserves. PHPT has been sufficiently capitalized by the Parent to support the additional reserve liabilities.

B. Administrative Services Only (ASO)

As previously mentioned, the CRA between PHPT and the State of Tennessee does not hold PHPT financially responsible for medical claims incurred through December 31, 2006. This type of arrangement is considered "administrative services only" as defined by the NAIC guidelines. Under the NAIC guidelines for ASO lines of business, the financial statements for an ASO exclude all income and expenses related to claims, losses, premiums, and other amounts received or paid on behalf of the uninsured ASO plan. In addition, administrative fees and revenue are deducted from general administrative expenses. Further, ASO lines of business have no liability for future claim payments, thus, no provisions for IBNR are reflected in the balance sheet. Although PHPT is under an ASO arrangement as defined by NAIC guidelines,

the CRA requires a deviation from those guidelines. The required submission of the TennCare Operating Statement should include quarterly and year-to-date revenues earned and expenses incurred as a result of the contractor's participation in the State of Tennessee's TennCare program as if PHPT were still operating at-risk. As stated in Section 2-10.i. of the CRA, PHPT is to provide "an income statement addressing the TennCare operations." TennCare HMOs provide this information on the Report 2A submitted as a supplement to the NAIC financial statements. No deficiencies were noted in the preparation of PHPT's Report 2A for the period ending December 31, 2005.

C. Medical Services Monitoring

Effective July 1, 2005, the CRA requires PHPT to submit a Medical Services Monitoring report (MSM) on a monthly basis. The MSM accounts for medical payments and IBNR based upon month of service as compared to a target monthly amount for the enrollees' medical expenses. Although estimates for incurred but not reported claims for ASO plans are not included in the NAIC financial statements, these estimates are required to be included in the MSM. PHPT submitted monthly MSM reports which included actual and estimated monthly medical claims expenditures to be reimbursed by the TennCare Bureau. The estimated monthly expenditures were supported by a letter from an actuary which indicated that the MSM estimates for IBNR expenses were reviewed for accuracy. No discrepancies were noted during the review of documentation supporting the amounts reported on the MSM report.

D. Schedule of Examination Adjustments to Capital and Surplus

There were no adjustments to capital and surplus as a result of the examination.

VII. DETAIL OF TESTS CONDUCTED – CLAIMS PROCESSING SYSTEM

A. Time Study of Claims Processing

The purpose of conducting a time study of claims is to determine whether claims were adjudicated within the time frames set forth in Tenn. Code Ann. § 56-32-226(b)(1) and Section 2-18. of the CRA. The statute mandates the following prompt payment requirements:

> The health maintenance organization shall ensure that ninety percent (90%) of claims for payments for services delivered to a TennCare enrollee (for which no further written information or substantiation is required in order to make payment) are paid within thirty (30) calendar days of the receipt of such claims. The health maintenance organization shall process, and if appropriate pay, within sixty (60) calendar days ninety-nine point five percent (99.5%) of all provider claims for services delivered to an enrollee in the TennCare program.

> (A) “Pay” means that the health maintenance organization shall either send the provider cash or cash equivalent in full satisfaction of the allowed portion of the claim, or give the provider a credit against any outstanding balance owed by that provider to the health maintenance organization.
>
> (B) “Process” means the health maintenance organization must send the provider a written or electronic remittance advice or other appropriate written or electronic notice evidencing either that the claim had been paid or informing the provider that a claim has been either partially or totally “denied” and specify all known reasons for denial. If a claim is partially or totally denied on the basis that the provider did not submit any required information or documentation with the claim, then the remittance advice or other appropriate written or electronic notice must specifically identify all such information and documentation.

TDCI currently determines compliance with Tenn. Code Ann. § 56-32-226(b)(1) by testing in three-month increments quarterly data file submissions from each of the TennCare MCOs. Each month is tested in its entirety for compliance with the prompt pay requirement of Tenn. Code Ann. If a TennCare MCO fails to meet the prompt pay standards in any of the three months tested, TDCI, at a minimum, requires claims data submissions on a monthly basis for the next three months to ensure the MCO remains compliant.

The prompt pay testing results for the examination period are as follows.

	Clean claims Within 30 days	All claims Within 60 days	Compliance
T.C.A. Requirement	90%	99.5%	
January 2003	99%	99.5%	Yes
April 2003	97%	99..9%	Yes
July 2003	85%	99.7%	**No**
August 2003	96%	99.7%	Yes
October 2003	99%	99.9%	Yes
January 2004	100%	99.9%	Yes
April 2004	98%	99.9%	Yes
July 2004	98%	99.9%	Yes
October 2004	100%	99.8%	Yes
January 2005	99%	99.9%	Yes
February 2005	100%	99.9%	Yes
March 2005	100%	100.0%	Yes
April 2005	100%	100.0%	Yes
May 2005	100%	100.0%	Yes
June 2005	100%	100.0%	Yes
July 2005	100%	99.9%	Yes
August 2005	100%	100.0%	Yes
September 2005	100%	100.0%	Yes
October 2005	100%	100.0%	Yes
November 2005	100%	100.0%	Yes
December 2005	100%	99.9%	Yes
January 2006	95%	99.9%	Yes
February 2006	97%	100.0%	Yes
March 2006	88%	100.0%	**No**
April 2006	84%	99.9%	**No**
May 2006	99%	100.0%	Yes
June 2006	100%	100%	Yes
July 2006	98%	100.0	Yes

PHPT processed claims timely in accordance with Tenn. Code Ann. § 56-32-226(b)(1) claims processing requirements for the examination period with the exception of July 2003, March 2006 and April 2006. PHPT did not process claims

timely in accordance with Tenn. Code Ann. § 56-32-226(b)(1) for the months of July 2003, March 2006 and April 2006.

Management's Comments

Management concurs.

B. Determination of the Extent of Test Work of the Claims Processing System

Several factors were considered in the determination of the extent of testing performed on PHPT's claims processing system.

The following items were reviewed to determine the risk that PHPT had not properly processed claims:

- Prior examination findings related to claims processing
- Complaints or independent reviews on file with TDCI related to accurate claims processing
- Results of prompt pay testing by TDCI
- Results reported on the claims payment accuracy reports submitted to TDCI and the TennCare Bureau
- Review of the preparation of the claims processing accuracy reports
- Review of internal controls.

C. Claims Payment Accuracy Report

Section 2-9. of the CRA requires that 97% of claims are paid accurately upon initial submission. PHPT is required to submit quarterly a claims payment accuracy report 30 days following the end of each quarter.

PHPT reported the following results for the examination period:

	Results Reported	Compliance
First Quarter 2003	98.56%	Yes
Second Quarter 2003	98.76%	Yes
Third Quarter 2003	98.76%	Yes
Fourth Quarter 2003	98.70%	Yes
First Quarter 2004	97.80%	Yes
Second Quarter 2004	99.70%	Yes
Third Quarter 2004	99.80%	Yes
Fourth Quarter 2004	98.80%	Yes
First Quarter 2005	97.86%	Yes
Second Quarter 2005	98.43%	Yes

Third Quarter 2005	97.52%	Yes
Fourth Quarter 2005	97.43%	Yes
First Quarter 2006	97.48%	Yes
Second Quarter 2006	95.57%	**No**

During the examination period, PHPT was in compliance with Section 2-9 of the CRA, with the exception of the second quarter of 2006. PHPT did not pay claims accurately for the second quarter of 2006 in accordance with Section 2-9 of the CRA, which requires that 97% of claims to be paid accurately upon initial submission.

Management Comments

Management concurs.

1. Procedures to Review the Claims Payment Accuracy Reporting

   The review of the claims processing accuracy report included an interview with responsible staff to determine the policies, procedures, and sampling methodologies surrounding the preparation of the claims payment accuracy report. This review included verification that the number of claims selected by PHPT constituted an adequate sample to represent the population. These interviews were followed by a review of the supporting documentation used to prepare the fourth quarter 2005 claims payment accuracy report. In addition TDCI selected ten claims with errors at random for review. The selected claims were reviewed to determine that the information on the supporting documentation was correct. The supporting documents were tested for mathematical accuracy. The amounts from the supporting documentation were traced directly to the actual report filed with TennCare.

2. Results of Review of the Claims Payment Accuracy Reporting

   TDCI's and the Comptroller's review of the third and fourth quarter 2005, noted no discrepancies in the preparation and reporting review of the claims payment accuracy reports.

D. Claims Selected For Testing From Prompt Pay Data Files

TDCI relied upon the Agreed Upon Procedures Report for the period July 1, 2005 through September 30, 2005, issued by the Comptroller of the Treasury, Division of State Audit. The Comptroller tested claims selected from the third quarter 2005 prompt pay data files previously submitted to TDCI. For each claim processed, the data files included the date received, the date paid, the amount paid, and if applicable, an explanation for denial of payment.

The number of claims selected for testing was not determined statistically. The results of testing are not intended to represent the percentage of compliance or non-compliance for the total population of claims processed by PHPT.

To ensure the third quarter 2005 data files included all claims processed in those months, the total amount paid per the data files was reconciled to the triangle lags and to the general ledger for the respective accounting periods to within an acceptable level.

The Agreed Upon Procedures Report issued by the Comptroller of the Treasury, Division of State Audit, noted the following conclusions:

- For 60 of the 60 claims, the amount adjudicated to the provider was correct.
- For 4 of the 60 claims, third-party liabilities were appropriately deducted from the amount paid. All other claims were not applicable.
- For 60 of the 60 claims, a duplicate claim was not paid.
- For 53 of the 60 claims, the amount paid to the provider agreed with the amount billed to TennCare. The other 7 claims were properly denied and not paid.
- For 60 of the 60 claims, the amount paid or denied by the MCO agreed with the claims encounter data submitted to TennCare.
- For 60 of the 60 claims, the information on the claim agreed with the encounter data in the TennCare Management Information System.
- For 58 of the 60 claims, the enrollee was an eligible TennCare recipient at the date of service. The other 2 enrollees were not eligible recipients on the date of service.
- For 40 of the 60 claims, the reimbursement rate had not changed since April 16, 2002. The rate changed for 10 claims to correct transposed fees for professional and technical procedure codes modifier. A 1.5% rate increase directive was given by the TennCare Bureau for 8 claims. A pre-freeze annual contract increase of the DRG (diagnosis related group) by 75% of the CPI (consumer price index) was given for 2 claims.
- For 60 of 60 claims, the claim was adjudicated in a timely manner.

E. Pended Claims Testing

The purpose of analyzing pended claims is to determine if a significant number of claims are unprocessed and whether a material liability exists for the unprocessed claims.

The September 30, 2005 pend file was selected for testing. Review of the pended claims does not indicate that PHPT has a significant number of claims over 60 days old. No material liability exists for claims pended over 60 days.

F. Electronic Claims Capability

Section 2-9.g. of the CRA states, "The CONTRACTOR shall have in place a claims processing system capable of accepting and processing claims submitted electronically with the exception of claims that require written documentation to justify payment …." The electronic billing of claims allows the MCO to process claims more efficiently and cost effectively.

The Health Insurance Portability and Accountability Act, Title II (HIPAA) required that all health plans be able to transmit and accept all electronic transactions in compliance with certain standards as explained in the statute by October 15, 2002. The U.S. Department of Health and Human Services extended the deadline until October 15, 2003, for health plans requesting additional time. Failure to comply with the standards defined for the transactions listed may result in the assessment of substantial penalties.

PHPT has implemented the necessary changes to process claims per the standards outlined by HIPAA.

G. Mailroom and Claims Inventory Controls

The purpose for the review of mailroom and claims inventory controls is to determine that PHPT's procedures ensure that all claims received from providers are either returned to the provider where appropriate or processed by the claims processing system. The review of mailroom and claims inventory controls included a walk through with mailroom and claims processing personnel.

Ten claims were judgmentally selected from a batch of incoming mail on July 12, 2006, to determine if the claims were entered into the claims processing system with the correct date received. Five of the ten claims were entered into the claims processing system with the correct date received. The other five claims could not be found in the claims processing system. Upon investigation, examiners discovered a system control failure that resulted in these claims not being posted to the claims processing system. This systems failure occurred during a file transfer from MACESS to AMYSIS. MACESS is the claims imaging software and AMISYS is the software used to adjudicate claims. Because automated processes do not include transfer on the weekend, a manual override is required. For the claims selected, the manual override was not performed. Without the manual override, claims could remain suspended for an unacceptable length of time. Controls should be updated to ensure that the manual override is always performed. PHPT should develop procedures to ensure that all batches of claims are successfully transferred to the claims processing system.

Management's Comments

Management concurs. Controls have been updated to ensure that the manual override is always performed. PHPT has developed procedures to ensure that all batches of claims are successfully transferred to the claims processing system.

VIII. REPORT OF OTHER FINDINGS AND ANALYSES – COMPLIANCE TESTING

A. Provider Complaints

Provider complaints were tested to determine if PHPT properly responded to all provider complaints in a timely manner. Ten provider complaints were selected from a list provided by PHPT. Tenn. Code Ann. § 56-32-226 states:

> The health maintenance organization must respond to the reconsideration request within thirty (30) calendar days after receipt of the request. The response may be a letter acknowledging the receipt of the reconsideration request with an estimated time frame in which the health maintenance organization will complete its investigation and provide a complete response to the provider. If the health maintenance organization determines that it needs longer than thirty 30 calendar days to completely respond to the provider, the health maintenance organizations reconsideration decision shall be issued within sixty (60) calendar days after receipt of the reconsideration request, unless a longer time to completely respond is agreed upon in writing by the provider and the health maintenance organization.

For the ten provider complaints tested, PHPT failed to respond to the provider within 30 days or notify the provider that the reconsideration would take longer than thirty days. Six of the complaints were not resolved within sixty days.

Management Comments

Management concurs with this finding. PHP is resolved to correct this deficiency in order to respond to provider complaints in a timely manner.

B. Provider Manual

The HMO's provider manual informs healthcare providers of applicable policies and procedures to be used to carry out their responsibilities as set forth in their provider agreements. The provider manual outlines guidelines to be followed by providers to assure that claims are processed accurately and timely. In addition, the provider manual informs providers of the correct procedures to follow in the event of a disputed claim.

The provider manual or provider reference guide is incorporated by reference into the terms of PHPT's provider agreements. The provider manual was submitted to TDCI for approval pursuant to Tenn. Code Ann. § 56-32-203(c)(1) on July 6, 2004. The version submitted to the examiner during fieldwork was dated July 1, 2004. TDCI issued a Notice of Filing Deficiency on July 13, 2004 based on the review of the provider manual filed with TDCI. PHPT did not respond to the Notice of Filing Deficiency.

On January 18, 2006, in connection with the review of provider agreement templates, TDCI reminded PHPT that a Provider Manual must be submitted as a material modification to PHPT's Certificate of Authority. Review of the PHPT website found that a different provider reference guide is currently in use with a version date of January 1, 2006. To date, this version has not been submitted to TDCI for prior approval.

PHPT is required to file a notice and obtain the Commissioner's approval prior to any material modification of the operational documents in accordance with Tenn. Code Ann. § 56-32-203(c)(1). PHPT's continued use of unapproved operational documents is a violation of this statute. TDCI reserves the right to pursue penalties as described in Tenn. Code Ann. § 56-32-220 and Tenn. Code Ann. § 56-32-216.

Management Comments

Management concurs with this finding. PHP has modified the Provider Manual to resolve deficiencies and is working with our attorney to submit this document to TDCI for approval of this material modification.

C. Provider Agreements

Agreements between an HMO and medical providers represent operational documents to be prior approved by TDCI in order for TDCI to grant a certificate of authority for a company to operate as an HMO as provided by Tenn. Code Ann. § 56-32-203(b)(4). The HMO is required to file a notice and obtain the Commissioner's approval prior to any material modification of the operational documents in accordance with Tenn. Code Ann. § 56-32-203(c)(1). Additionally, the TennCare Bureau has defined through contract with the HMO minimum language requirements to be contained in the agreement between the HMO and medical providers. These minimum contract language requirements include, but are not limited to, standards of care, assurance of TennCare enrollees' rights, compliance with all federal and state laws and regulations, and prompt and accurate payment from the HMO to the medical provider.

Per Section 2-9. of the CRA between PHPT and the TennCare Bureau, all template provider agreements and revisions thereto must be approved in advance by the TennCare Division, Department of Commerce and Insurance, in accordance with statutes regarding the approval of an HMO's certificate of authority and any material modification thereof. Additionally, Section 2-18. of the CRA requires that all provider agreements executed by PHPT shall meet the current requirements listed in Section 2-18.

Three executed provider contracts were reviewed to determine compliance with Section 2-18. of the CRA. The provider contracts were for a hospital/facility, primary care physician and a physician group.

TDCI has approved for PHPT the following related contract templates:

- On January 18, 2006, the facility/hospital contract for new providers was approved by TDCI. On November 1, 2005, the facility/hospital contract addendum for existing providers was approved by TDCI.
- On January 18, 2006, the physician group contract for new providers was approved by TDCI. On November 17, 2005, the contract addendum for physician group contract for existing providers was approved by TDCI.
- On January 18, 2006, the primary care physician contract for new providers was approved by TDCI. On November 1, 2005, the contract addendum for primary care physician contract for existing providers was approved by TDCI.

For two of the executed provider contracts selected for testing, none of the approved templates were in use.

- The contract for a physician group was signed in 1999. It was amended in 2000 with signatures and again in 2002 without signatures.
- The contract for a primary care physician was signed in 2002. PHPT amended the agreement in 2002 without signatures.

The hospital/facility contract was signed in 2002. PHPT amended the agreement in 2002 and again in 2005 with the approved template. Even though the agreement specifically states that both parties must sign any proposed amendments, there were no signatures on the amendments.

PHPT could not provide evidence that for each contract tested that the provider had actually received the amendment from 2002 or that the provider had agreed to its terms. Additionally, the contract lacked changes mandated by the CRA in subsequent amendments to Section 2-18.

Section 2-18.cc of the CRA requires the following language in all provider agreements to insure that MCOs do not effect changes to contracts unilaterally:

> Specific procedures and criteria for any alterations, variations, modifications, waivers, extension of the agreement termination date, or early termination of the agreement and specify the terms of such change. If provision does not require amendments to be valid only when reduced to writing, duly signed and attached to the original of the agreement, then the terms must include provisions allowing at least thirty (30) days to give notice of rejection and requiring that receipt of notification of amendments be documented (e.g., Certified Mail, facsimile, hand-delivered receipt, etc);

Significant revisions have been required to provider agreement templates since 2002 per PHPT's contract with the TennCare Bureau. PHPT must ensure that as provider agreement templates are updated for new requirements of the CRA and approved by TDCI, providers are notified of the amendments as required by Section 2-18.cc of the CRA.

Management's Comments

Management concurs with this finding. PHP is working with our attorney to ensure that all provider agreement templates are updated for new requirements of the CRA and approved by TDCI. PHP will ensure providers are notified of the amendments as required by Section 2-18.cc of the CRA.

D. Provider Payments

Examiners tested capitation payments to providers during 2005 to determine if PHPT had complied with the payment provisions set forth in its capitated provider agreements. Review of payments to capitated providers indicated that all payments were made per contract requirements.

E. Subcontracts

HMOs are required to file a notice and obtain the Commissioner's approval prior to any material modification of operational documents in accordance with Tenn. Code Ann. § 56-32-203(c)(1). PHPT subcontracted with Community Service Agencies to coordinate the delivery of transportation. The subcontracts were executed without prior approval by TDCI or the TennCare Bureau.

On October 11, 2005, PHPT submitted for approval a subcontract and addendum for transportation services. On October 19, 2005, TDCI disapproved the subcontract and addendum because the filings lacked proof of TennCare Bureau approval as required by Sections 2-9.f and 2-17 of the CRA. Revised subcontracts were submitted again on August 31, 2006. On September 29, 2006, TDCI disapproved this version for lack of TennCare Bureau approval and other items.

PHPT's continued use of unapproved operational documents is a violation of Tenn. Code Ann. § 56-32-203(c)(1). TDCI reserves the right to pursue penalties as described in Tenn. Code Ann. § 56-32-220 and Tenn. Code Ann. § 56-32-216.

Management's Comments

Management concurs with this finding. PHP is working with our attorney to ensure that our Transportation Coordination Agreement is approved by TDCI. PHP's records show that the Transportation Coordination Agreement was approved by the Bureau of TennCare on March 7, 2001.

F. Non-discrimination

Section 2-24 of the CRA requires PHPT to demonstrate compliance with Federal and State regulations of Title VI of the 1964 Civil Rights Act, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1990, the Age of Discrimination Act of 1975 and the Omnibus Budget Reconciliation Act of

1981. Based on discussions with various PHPT staff and a review of policies and related supporting documentation, PHPT was in compliance with the reporting requirements of Section 2-24 of the CRA.

G. Stabilization

Section 3-10.h.2(a) of Amendment 3 to PHPT's CRA requires PHPT to comply with the following:

> The CONTRACTOR shall reimburse providers according to reimbursement rates, reimbursement policies and procedures, and medical management policies and procedures in effect as of April 16, 2002, for covered services as defined in Section 3-10.h.2(j), unless otherwise directed by TENNCARE, with funds deposited by TENNCARE, with funds deposited by the State for such reimbursement by the CONTRACTOR to the provider.

PHPT's management confirmed compliance with all stabilization requirements. During testing of financial, claims processing, and provider contracts, TDCI noted no instances of non-compliance with this CRA requirement.

H. Internal Audit Function

The importance of an internal audit function is to provide an independent review and evaluation of the accuracy of financial recordkeeping, the reliability and integrity of information, the adequacy of internal controls, and compliance with applicable laws, policies, procedures, and regulations. An internal audit function is responsible for performing audits to ensure the economical and efficient use of resources by all departments to accomplish the objectives and goals for the operations of the company. The internal audit department should report directly to the board of directors so the department can maintain its independence and objectivity.

PHPT's parent, Covenant Health, performs certain internal audit functions for PHPT. Covenant's internal audit department consults with PHPT management and regularly performs focused audits of areas where management has expressed concerns. Covenant's internal audit department also prepares the annual audit plan for the TennCare Bureau.

The manager of the Decision Support and Audit unit of PHPT performs claims testing and prepares the claims payment accuracy reports. The unit is separate from the claims processing department. The unit reports directly to the Chief Executive Officer.

I. HMO Holding Companies

Effective January 1, 2000, all HMOs were required to comply with Tenn. Code Ann., Title 56, Chapter 11, Part 2 – the Insurance Holding Company System Act of 1986. Tenn. Code Ann. § 56-11-205 states, "Every insurer and every health maintenance organization which is authorized to do business in this state and which is a member

of an insurance holding company system or health maintenance organization holding company system shall register with the commissioner…."

As noted in Section VI.A.8 of this report, the management agreement for PHPT has not been approved by the TennCare Division of the Department of Commerce and Insurance. Tenn. Code Ann. § 56-11-206(a)(2)(D) requires management agreements to be prior approved by TDCI.

Additionally as noted in Section VI.A.5 of this report PHPT failed to obtain prior approval for an extraordinary distribution of $9,133,336 as required by Tenn. Code. Ann. § 56-11-206(b)(1).

Management's Comments

See comments in Section 5 and 8 (Section VI.A.).

J. Behavioral Health Organization (BHO) Coordination

PHPT was in compliance with Section 2-3.c.2 of the CRA whereby effective July 1, 2002, "claims for covered services with a primary behavioral diagnosis code, defined as ICD 9-CM 290.xx- 319.xx'' are submitted to PHPT for timely processing and payment.

PHPT is required to refer unresolved disputes between the HMO and BHO to the State for a decision on responsibility after providing medically necessary services. PHPT indicated that it did not have any ongoing disputes with the BHO.

K. Contractual Requirements for ASO Arrangements

As previously mentioned, effective July 1, 2002, PHPT's CRA was amended so that PHPT would operate as an ASO. As a result, the provisions tested below are a requirement for transactions with dates of service after July 1, 2002.

1. Medical Management Policies

Section 2-2.r. of the CRA requires PHPT to comply with the following as it relates to the TennCare line of business:

> Agree to reimburse providers for the provision of covered services in accordance with reimbursement rates, reimbursement policies and procedures and medical management policies and procedures as they existed on April 16, 2002, unless otherwise directed or approved by TennCare, and to submit copies of all medical management policies and procedures in place as of April 16, 2002, to the State for purpose of documenting medical management policies and procedures before final execution of this Amendment.

PHPT's management confirmed compliance with the requirements described above. During testing of claims processing and provider contracts, no deviations

to the requirement were noted.

2. Provider Payments

Section 3.10.h.2(b) of the CRA states that PHPT "shall release payments to providers within 24 hours of receipt of funds from the State." PHPT contracts with ABF in St. Louis, Missouri, for the printing and mailing of claims checks. For a test month, paid dates were compared to reimbursement dates by the TennCare Bureau. None were greater than one day.

3. 1099 Preparation

Section 3-10.h.2(c) of the CRA states that PHPT "shall prepare and submit 1099 Internal Service Reports for all providers to whom payment is made." Based on TDCI's review, PHPT has complied with this requirement.

4. Interest Earned on State Funds

Section 3-10.h.2.(d) of the CRA states interest generated by funds on deposit for provider payments related to the non-risk agreement period shall be the property of the State. The interest amount earned on the funds reported on PHPT's monthly bank statement should be deducted from the amount of the next remittance request from the TennCare Bureau.

PHPT did not deduct interest earned on State funds for September 2005, October 2005 and November 2005 when notified via bank statement on the next funding request. PHPT delayed the deduction for all three months until December 27, 2005. PHPT should ensure as monthly interest is earned, a deduction is reported on the next funding request to the state per Section 3-10.h.2.(d) of the CRA.

Management's Comments

Management concurs.

5. Recovery Amounts/Third Party Liability

Section 3-10.h.2.(f) and (g) of the CRA require third party liability recoveries and subrogation amounts related to the non-risk agreement period be reduced from medical reimbursement requests of the TennCare Bureau. As third party liability and subrogation amounts are recovered, PHPT should reduce the next medical reimbursement request to the TennCare Bureau for the amounts recovered.

Subrogation amounts for the period October 2005 through November 2005 were deducted from the December 27, 2005 funding request to the State. Section 3-10.h.2.(g) of the CRA was violated since the subrogation recovery deposits were not deducted from the next funding request. PHPT should reduce the next medical reimbursement request to the TennCare Bureau as amounts are

recovered for subrogation.

Management's Comments

Management concurs.

6. Pharmacy Rebates

Section 3-10.h.2.(f) of the CRA states that pharmacy rebates collected by PHPT shall be the property of the State. The pharmacy program was carved out of the HMO's responsibility in July 2003. PHPT was in compliance with this requirement.

L. Conflict of Interest

Section 4-7 of the CRA warrants that no part of the amount provided by TennCare shall be paid directly or indirectly to any officer or employee of the State of Tennessee as wages, compensation, or gifts in exchange for acting as an officer, agent, employee, subcontractor, or consultant to PHPT in connection with any work contemplated or performed relative to this Agreement unless otherwise authorized by the Commissioner, Tennessee Department of Finance and Administration.

Conflict of interest requirements of the CRA were expanded to require an annual filing certifying that the MCO is in compliance with all state and federal laws relating to conflicts of interest and lobbying.

Failure to comply with the provisions required by the CRA shall result in liquidated damages in the amount of one hundred ten percent (110%) of the total amount of compensation that was paid inappropriately and may be considered a breach of the CRA.

The MCO is responsible for maintaining adequate internal controls to detect and prevent conflicts of interest from occurring at all levels of the organization and for including the substance of CRA conflict of interest clauses in all subcontracts, provider agreements, and any and all agreements that result from the CRA.

PHPT demonstrated the following efforts to ensure compliance with the conflict of interest clause of the CRA:

- The organizational structure of PHPT includes a compliance officer who reports to the president of PHPT, who reports to the board of directors of PHPC.
- PHPT has written conflict of interest policies and procedures in place.
- The written policies and procedures outline steps to report violations.
- The policy indicates all business associates are to comply with PHPT's conflict policy.

- Employees complete conflict of interest certificates of compliance annually per the written policy and procedures.

The examiners hereby acknowledge the courtesy and cooperation of the officers and employees of PHPT.